

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2016
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 TERRE HAUTE, IN 47802
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 04/13/16</p> <p>Facility Number: 000887 Provider Number: 15G373 AIM Number: 100249240</p> <p>At this Life Safety Code survey, Mosaic was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, common areas and sleeping rooms. The facility has the capacity for 8 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety,</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K S051 Bldg. 01	<p>Chapter 6, rated the facility Slow with an E-Score of 3.2.</p> <p>Quality Review completed on 04/15/16 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was provided in accordance with Section 9.6. Section 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, Section 7-4.3 states all apparatus requiring resetting to maintain normal operation shall be reset as promptly as possible after each test and alarms. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Property Manager on 04/13/16 at 11:24 a.m., he</p>	K S051	<p>Inregards to evidence cited by the Life Safety Code Specialist, The property manager found the correct key for the pull box and made a copy of the key to be kept by him One of the keys was returned to the home and placed it in the proper spot The facility staff were trained on use and maintenance of the fire system and where the key and spare are kept. .</p> <p>Mosaichas implemented systematic changes to ensure the findings of this survey do not recur. Per policy and procedure, an inspection of the facility is completed every other month to assure the fire safety system is working properly. Each</p>	04/15/2016

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K S123 Bldg. 01	<p>was unable to open the pull station with the key provided at the facility. If this pull station was accidentally or intentionally activated the fire alarm system could not be reset until the fire alarm service company's arrival. Based on interview with the Property Manager at the time of observation, he stated the key at the facility was the wrong key and attempted to locate another key that would reset the pull station. He was unable to locate a working key.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every bathroom door is designed to allow opening from the outside during an emergency when locked. 32.2.2.5.4, 33.2.2.5.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 bathroom doors on the women's side could be opened from the outside during an emergency when locked. This deficient practice could affect any client using the bathroom.</p> <p>Finding includes:</p> <p>Based on observation with the Property Manager on 4/13/16 at 11:30 a.m., the bathroom door on the women's side of the facility could be locked from the inside. Based on an interview with the</p>	K S123	<p>inspection is reviewed by the agency Safety Committee Chairman. As a further means to assure this deficiency does not recur, Mosaic management conducts multiple weekly visits to each facility to assure the site is properly maintained. During each visit and inspection, agency management assures the fire safety system is working properly at the facility.</p> <p>In response to the findings made by the Life Safety Code Surveyor, a new bathroom door key was made to ensure the door can be opened. The key is placed on the wall above the door for emergency access. A spare key has also been placed on the staff key ring for back up. Mosaic has implemented systematic changes to ensure the findings of this survey do not recur. Per policy and procedure, Mosaic conducts safety inspections at each facility operated by the agency on a quarterly basis. The findings of each inspection are reviewed by the agency Safety Committee Chairperson and the committee</p>	04/15/2016

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K S150 Bldg. 01	<p>Property Manager at the time of observation, no key or tool was available to unlock the bathroom door.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on interview and observation, the facility failed to ensure 1 of 1 new draperies located in the kitchen and 1 of 1 curtains in the dining room were flame resistant. LSC Section 10.3.1 requires that draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all clients and staff within the facility.</p> <p>Findings include</p> <p>Based on interview of the Property Manager on 04/13/16 at 11:27 a.m., the curtains in the kitchen and living room area on the men's side of the facility were new and observation of the attached tags did not indicate the curtains were</p>	K S150	<p>itself.</p> <p>In regards to evidence cited by the medical surveyor, the curtain were taken down in front of the surveyor. New flame resistant treatment will be completed on all curtains prior to hanging and then thereafter In order to assure that this deficiency doesnot recur in this facility, Per Mosaic policy and procedure, Annually the property manager will check the spray dates and reapply as needed. . As a further means to assure this deficiency does not recur, Mosaic management conducts multiple weekly visits to each facility to assure the site is properly maintained. As a part of this visit,each manager assures the home is in sufficient condition for client use.</p>	04/15/2016

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	inherently flame resistant. Interview with the Property Manager at 11:29 a.m. revealed additional information regarding the curtains being flame retardant was not readily available for review.				